Keeping Australians Healthy: The Challenge to Physiotherapy Practice Posed by the Concept of the New Public Health

This Keynote Address considers issues around 'The Healthy Australian', the theme of the 1988 APA National Conference.

The concept of the New Public Health requires physiotherapists to review the role they traditionally have held in health care delivery, and to address some key issues in order to meet the needs of their patients and clients more effectively. These issues include developing the most appropriate client/professional relationship, and considering the main elements in education for health and in supporting clients achieve effective coping skills. This paper also addresses some practicalities in legitimizing physiotherapists' involvement in disease prevention and health promotion, and in working with clients in ways that allow a balance of responsibility to be shared appropriately by both parties.

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The choice of the theme 'The Healthy Australian' for this National Conference in our Bicentenary year is an indication of the importance physiotherapists are beginning to put on the prevention of disease and injury, the maintenance of existing health, and the promotion of optimal quality of life for all Australians.

Although these concepts are not foreign to our profession, they pose some particular challenges. This paper will consider some key issues that we need to address in wanting to keep Australians healthy, and the implications for physiotherapy practice arising from these issues.

Our traditional role in the health care services is clearly spelt out in our professional title — the word 'physiotherapist' refers to a person who is trained to provide treatment by physical means. But for treatment to be required, there is an underlying assumption that something is wrong. So our training equips us to function primarily in illness and injury care rather than health care.

For treatment to be instigated, a diagnosis must be made. A diagnosis is usually made only when a person chooses to present and ask for care, and initiate a relationship with us. In these circumstances we are regarded as service providers responding in a reactive way to our clients' requests and requirements.

Providing a service in this way fits the traditional medical model, and this model is found to dominate our way of working from the time we enter physiotherapy training. However, the work of the World Health Organisation (WHO) on a global scale has shown recognition of some of the problems inherent in working solely within this traditional model, and WHO policy is suggesting that member nations consider other approaches to health care (WHO 1986a). One of these that is particularly relevant to us is the approach that is being put forward under the banner of 'the new public health' (Kickbusch 1986).

The New Public Heath

This phrase, 'the new public health', needs to be explored in order to clarify the full meaning of the term. To health care practitioners generally, public health in the past has been viewed as an effort organized by society, particularly at a government level, to reduce disease and death within the whole population. Attempts to do this have concentrated primarily on endeavouring to modify the physical environment and controlling the spread of communicable disease. Sanitation and immunization come readily to mind as public health strategies that have proved very effective in reducing health problems.

It can clearly be seen that the strategies deemed appropriate as public health measures are dependent on how health is defined. Sanitation and immunization fit well the germ theory of disease (Maykovich 1980) where health is defined as the absence of these diseases (Figure 1), and attacking the 'germs' is the logical way to combat this problem.

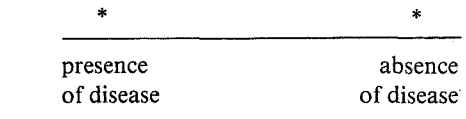

Figure 1: The old health continuum

However, recently our definition of health has undergone a marked change, and as a result our definition of public health has had to alter too. Our new view of health accepts that some diseases are chronic — absence of disease is not a feasible choice — and yet we have also come to accept that individuals can learn to function well within the limits of a chronic disease. Consequently, we can draw up a new continuum where we can replace 'absence of disease' with 'ability to function adequately'. Since this functioning ability can be improved, so we can extend the continuum to include a more positive state of health, and call this 'optimum well-being' (Figure 2). The new public health operates particularly on the right side of this continuum.

This new view of health is one of a social and ecological system that is inextricably bound up with our everyday living — our lifestyle patterns and our social and physical environments are being shown to be key determinants of health. Efforts to enhance health must therefore address raising awareness about these determinants, and providing opportunities for individuals to reduce their risks of contracting disease, and better manage existing problems.

This is the province of the new public health. It is primarily concerned with measures that will move people from the centre of our continuum towards the right and enable them to achieve optimum well-being. It is concerned with addressing the common health dilemmas that face us in the latter part of the 20th century. When these are analysed, we find that the main health problems confronting our society today have some common characteristics (Better Health Commission 1986). Diseases such as cardiovascular disease, cancer, arthritis, mental health problems and AIDS:

- tend to develop over a long period
- have an unclear relationship between cause and effect
- are rarely able to be cured and therefore
- lend themselves more to preventive approaches and disease management strategies.

To combat these health problems, public health in 1988 is addressing three areas of activities:

- protection of people from hazards in the total environment,
- prevention of unnecessary morbidity and premature mortality, and
- promotion of well-being and improved quality of life (Lin 1986).

In order to help the population move from a state of functioning adequately to a state of optimum well-being we have to be assertive. We can no longer wait for the patient or client to present with symptoms. We have to take the initiative and make the assumption that most of the community would like to be as far along the line to the right as possible. Rather than assessing our presenting clients for individual treatments, we have to consider whether it is our role to step in and work with individuals, groups or whole populations to promote health or prevent disease proactively and, in a sense, unasked.

Within the new public health, the greatest effort must lie in enabling individuals, groups and populations to adopt healthy behaviours. The World Health Organisation has stated that efforts need to be made 'to encourage people to want to be healthy, to know how to stay healthy, to do what they can individually and collectively to maintain health, and to seek help as needed' (WHO 1986 a).

So along with this wider concept of public health goes the implicit understanding that health professionals are expected not only to do things *for* people or *to* people, but to enable people to help themselves.

Our goal, therefore, is to take an enabling role in fostering self-reliance and self-responsibility for health in the people with whom we work.

You may well ask 'What's new?' Surely these concepts have been around for ages. Enabling the disabled to live independently has always been our goal. The problem seems to lie in the way we convert this philosophy into action. So what we need to address today is providing the answer to the question: How do we best convert these theories into practice?

Theory to Practice

Within the new public health the physiotherapist has two main tasks — to help the client in lerning, and to help the client in coping. In order to achieve this, the following key aspects need to be explored:

1. The types of relationships that need to develop between the physiotherapist and the client for learning and coping to be enhanced

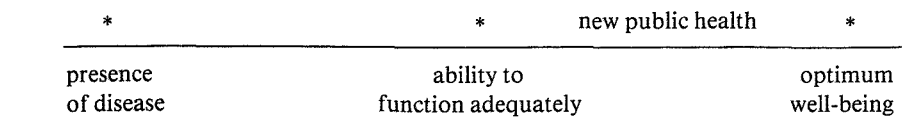

Figure 2: The new health continuum

2. The main elements in education for health
3. The main elements in supporting clients develop effective coping skills

1. Relationship between physiotherapist and client

As physiotherapists, we have on the whole done most of our clinical training in large teaching hospitals where acute management and treatment are the order of the day. Our way of relating to patients and clients has been learnt in this setting and most of us find that we transfer this relationship into virtually all of our interactions.

In 1956, Szasz and Hollender set out what they thought were the models of physician/patient relationship existing thirty years ago, and most current researchers in this area feel that their findings are just as viable in the 1980s, and can be generalized to all health professionals, including physiotherapists (Szasz and Hollender 1956). They set out three models of relationship:
1) the model of activity-passivity,
2) the model of guidance-cooperation
3) the model of mutual participation

In their model of activity-passivity, they describe a relationship where the health care practitioner actively administers to the submissive individual. They suggest that treatment takes place irrespective of the patient's contribution and regardless of the outcome. In the cases of surgery, or prescription of complex medications, or 'high-tech' diagnostic procedures, or life-saving routines, the expertise of the professional is unquestioned and the patient readily submits. This is the choice of relationship style that patients prefer in these situations, where they only feel secure when they can rely wholly on the expert. In addition, they may be too ill, too anaesthetised or too frightened and vulnerable to do anything else but submit.

The second model of guidance-cooperation is most commonly met in situations of acute illness where it is acknowledged that patients are conscious and have feelings and aspirations of their own. However, the passivity of the previous model is replaced with an expectation of cooperation and compliance, and a willingness to obey those in positions of power. All major decisions are made by the health care practitioner, and in most cases the patient accepts this state of affairs without question.

Their third model of mutual participation is stated by Szasz and Hollender to be philosophically and psychologically the model of choice. In this instance the health care practitioner and the patient are joint decision-makers, have mutual respect for each other and find the relationship satisfying to both. The patient is assumed to understand the situation and to be in a position to exert some choice.

They see this model to be appropriate in instances when individuals want to take care of themselves, when they need to cope on a daily basis with self-management of a chronic disease or the like, or when the treatment or prevention programme is essentially carried out by individuals themselves rather than by experts. They also point out that this model is a higher state of development in an evolutionary sense and requires more complex social and psychological skills.

Although Szasz and Hollander wrote their paper in the 1950s, what they described is entirely relevant today, and the three models can be easily observed in operation within the health care system. But what can also be observed is that health care practitioners tend to develop a set pattern of relating to their clients, and this may become rigid. Choice may not always be made between the three approaches, so that an entirely inappropriate interaction may occur.

In crisis situations we need to recognize that patients expect and require us to be active while they remain submissive. In these instances the first model is entirely appropriate, and most people will say that they find it a relief to hand over power to the health professional team when they or their family are in abnormally high risk situations of some sort or another. In fact they see it as an abdication of responsibility by the health professional if decisions are not made for them.

In situations where no crisis exists but where expert care is necessary, Szasz and Hollender's findings with doctors can be easily transposed to physiotherapists : as a profession we have worked hard and successfully to gain the confidence and trust of the communities in which we work, and we can hold our heads high as a respected discipline.

So the second model has a place when it is reasonable to direct patients using our expertise to treat them, and reasonable to expect compliance from them. We all recognize how pain and disability put human beings in a very vulnerable position : they are not able to think objectively and appreciate others doing it for them.

However, helping people move from the centre of our continuum towards the right is an entirely different matter. These individuals are assumed to be healthy enough to be not needing treatment in the usual sense of the word. In order to attain optimal well-being, they can get there themselves, but the role of the health professional is to facilitate their arrival. It is entirely inappropriate for them to be submissive, or even for them to be compliant. In all our dealings with individuals within the umbrella of the new public health the only model that is of lasting value is the mutual participation model where we give people the opportunity to make choices themselves, but our role is to help widen their options. Visually the patient and the professional appear equal and authority does not appear to be an issue; rather there is a sense of shared goals.

2. The meaning of education for health

If we are saying that people must be able to make decisions regarding their own health, then we need to develop strategies that foster negotiation and collaboration between clients and health care practitioners that lead to informed decision-making. This can be seen to be preferable to the conventional approaches used by members of our profession that seek just to promote compliance. Within the context of the new public health we need to develop a wide practical definition of education for health (Tones 1987) that embraces any activity that contributes to individuals learning to maintain or improve their health status.

But education for health does not simply mean provision of information for the acquisition of knowledge, but the fine combination of skills and attitudes with knowledge that may bring about behaviour change.

For a moment, let us explore the types of education to which physiotherapists have been exposed, in order to clarify the broad meaning of education.

The first type of education that usually comes to mind is the formal tuition we have all experienced in primary and secondary school and in tertiary institutions. Here our incentive to learn has been predominantly motivated by such external factors as examinations and the need to obtain documented qualifications. In these instances, almost all of us have been force fed with masses of information that we have apparently processed as required, because to be here today we must have passed the necessary examinations and received the appropriate documentation! So we are familiar with the educational approach that relies predominantly on information provision.

Secondly, as physiotherapists we have spent a large part of our clinical work in teaching individuals physical skills through explanation, demonstration, practice and feedback. In a large number of cases our patients and clients have succeeded in learning to walk or regaining co-ordinated control or using a muscle group effectively. So we are also familiar with the educational approach that is directive, and that achieves must of its effect with repetition.

However, continuously and inexorably we are subject to a third type of educational exposure. This is what we could call education for living, and it includes all the day-to-day experiences that we have throughout our lives. We are not conscious of this being a learning process, but since we undergo change in thoughts, feelings and action as a result of observing what happens around us, then we have to accept this observational learning as education just as validly. What is more, when we analyse this process, it can be seen that it actually contributes more to our health status than either of the other two types of learning experience. From our day-to-day learning we develop our lifestyle patterns of such essential activities as eating, sleeping, moving, relating to others and so on, all of which are part and parcel of our state of health.

Consequently, if we are wanting to move individuals along the continuum in order to enhance their well-being, it is unlikely that we will have much success in using either the classroom or the therapist/patient approach. It is far more logical to step in on an educational level that is already seen to be effective in influencing people's health behaviours.

This is much more easily said than done. If we try to analyse the reasons each of us takes up or changes some of our existing behaviours, it is likely we could list many variables that have exerted influence. Sometimes we can point to one strong reason for change; much more often the resulting behaviour has developed over a very long period with innumberable small but crucial factors determining the outcome.

Social psychologists who study this field have spelt out a sequence that usually occurs when individuals take up a new behaviou (Walker *et al* 1988). Suffice to say that the sequence has many components and that all must be completed if the new behaviour is to last. Basic to it all is the person's beliefs, values and attitudes.

The most critical attitude is that relating to learning. To learn effectively, there must be a desire to learn. This is the intrinsic motivation that is so hard to arouse, but I firmly believe that if we are going to achieve anything in enhancing individuals' attempts to move along our continuum, then we need to address this factor (Bandura 1977).

Rather than spending our time giving out information to people who are not able to comprehend it because they are not yet ready to hear it, we need to step back and work at getting them ready. In general, there are two key points to remember to make this easier: to involve our clients in identifying their own problems, and to work together with them to develop strategies that have meaning and relevance for those concerned.

3. The main elements in supporting clients develop effective coping skills

If we return for a moment to our continuum, we need to consider the qualities we value that are represented on the graph with the words 'optimum well-being'. The Macquarie Dictionary defines well-being as a 'good or satisfactory condition of existence'.

Although we can measure objectively, at the middle of our continuum, the extent to which an individual is functioning adequately, when we attempt to measure the degree to which a person feels their condition is good or satisfactory, we realise that this can only be assessed subjectively by the appraisal of the individual concerned. Assessment of quality of life is not able to be done by anyone else.

When something is perceived to impede the individual's progress along the continuum towards optimum well-being, we say that the individual is under stress. In these instances, the person's resources are taxed, and to remedy the situation a coping mechanism is set in motion.

Richard Lazarus, who has explored coping patterns extensively, defines coping as efforts to manage a troubled person-environment relationship (Folkman and Lazarus 1980). He sees it as either efforts to regulate distressing emotions — emotion-focused coping, or doing something to change for the better the problem causing the distress — problem-focused coping.

In other words, if we think we can do something, we cope by focusing on the problem; if we have to try to accept it, we cope by focusing on the emotion. But stress is not static: it changes all the time, and coping, being a relevant process, changes along with it.

Many studies have shown that people who develop effective coping skills are on the whole healthier than those who fail to gain them (Kobasa 1979). More importantly, it does not seem to be the degree of stress that a person is exposed to, but the person's appraisal of the situation and ability to respond in a positive manner that are far more indicative of whether they will remain healthy. Here again, enabling people to choose from a set of options is the role of choice for the health care worker — it is impossible for anyone else to say what is stressful to any individual, and by the same token to recommend a way of coping.

Consequently, the concept of people coping must be seen as something that the health care practitioner can enhance and facilitate occurring, but the direction taken and the strategies used must be chosen by the client. If we consider coping in relation to our concept of the new public health, we can easily see that any move from the centre to the right will entail developing effective coping patterns both for preventing disease, and very importantly, for learning to live with a chronic condition. For instance, helping patients and clients learn relaxation skills can be an invaluable contribution from the physiotherapist when deemed appropriate by the client.

What, then, are the implications arising for physiotherapy practice from these issues concerning stress and coping?

We know that for a person to become one of our clients, they are having to deal with many extra demands that they may regard as sources of stress. Pain, incapacity, strange environments, and invasive treatments may be added to the particular demands during illness of maintaining emotional balance and a satisfactory self-image, and relating well with family and friends (Folkman and Lazarus 1980).

Although we are physiotherapists concerned primarily with movement and physical function, we can easily recognize that we need to enable clients to develop adequate coping skills for them to gain maximum benefit from our treatments. Stress management should become a component of every physiotherapist/client interaction and general strategies to enhance coping should be built into every treatment plan.

But whereas we can use our expertise to decide on our clients' treatments, it is essential that we help them consider options in coping, and here the decision must be theirs. All the attitudes and skills we have discussed already today are pertinent to stress management: the relationship must be one of mutual participation, and the educational approach one of learning for living.

Related Issues

Having emphasized the importance of relating well with clients, and enabling them to learn and to cope, there are some further related issues that should be discussed.

Legitimizing Involvement in Prevention and Promotion

The first one concerns legitimizing our involvement in prevention and promotion. We have to work out an acceptable way to offer support without that support being requested. If we acknowledge that people take responsibility for their own quality of life, and yet that we have something to offer them, then we are abdicating our responsibility if we do not take steps to make clear to them what we can do.

Our training equips us to respond, to be reactive, to come forward when requested. It is foreign to many of us to take the first step and tell people that we can help them, instead of relying on the complex referral and networking system that currently exists to provide us with clients in both the public and private sectors.

Our training also emphasizes that we must work within a scientific framework, and that we have to justify our interventions with research to prove their relative effectiveness.

One of the ways that we can justify coming forward is to base our rationale for involvement on epidemiological studies rather than on pure clinical studies. Epidemiology embraces the study of the distribution and determinants of disease (McMahon and Pugh 1970). It provides information on statistical relationships that are seen to exist between clinical and pathological aspects of disease and the social and environmental factors that co-exist with or precede these conditions.

In the past, our justification for working with clients has been predominately based on the fact that the conditions with which they present are amenable to treatment by physical means. Instead, we can now justify our involvement through making use of epidemiological findings. For instance, many studies have shown that the main variable affecting quality of life in older age groups is physical activity level (WHO 1984). Physiotherapists do

not need to be told this : they know it empirically from seeing what happens to all parts of a person's life when they enable people to become mobile. But the health service decision makers may not be clear about the value of becoming active, and the public may have heard it, but do not have the wherewithal to do something about it.

Our role is clear in this example with older people. In and around our daily practice we can publicise and promote these research findings to justify and validate our involvement. Based on this scientific framework, we can provide a physiotherapy preventive service, and promote it as such. Meanwhile we can consider every elderly client as a whole, and regardless of their initial reason for attendance, exert efforts to support and encourage an increase in physical activity generally. We can also offer consultancy services to institutions, organizations and clubs involved with the aged, having developed a convincing rationale for our involvement. The strategies outlined here can be generalized to innumerable other groups of clients.

Professional Promotion

Another implication for us within the new public health, that arises from the above, is to consider *how* we can promote ourselves and our profession as active workers in the areas of protection, prevention and promotion, with due regard to professional and ethical considerations.

One of our problems lies in the way we have been classified up until now within the health service as a whole. We are stuck with the suffix 'therapist' hooked on the end of our occupational title. But change does not have to be regarded as a bad thing. Few professions in the conventional health scene are focusing strongly on promoting health, but due to consumer demand, the alternative therapies are having a field day. If we do not get a move on, we may miss out. Our task here is to promote social and preventive physiotherapy so it can take its place legitimately alongside social and preventive medicine.

The World Health Organisation, in recommending areas for action in health promotion, suggests that it is crucial for the health sector to 'reorient health services . . .increasingly in a health promotion direction, beyond [their] responsibility for providing clinical and curative services' (WHO 1986b). We have nothing to stop us being on the forefront of this movement, and everything to gain. Although we must be careful not to step beyond our ethical boundaries, by the same token, we must not be timid in letting our communities know what we are capable of doing, and what we wish to do.

We owe it to our clients to present ourselves appealingly and to clarify for them, but also for ourselves, the breadth of what we can offer. But this brings us to the dilemma of whether, in offering a broadened range of services, we could be accused of overservicing. Imagine the response of the health funds in the present climate if every client seen had an additional category of prevention added to their account!

Here, again, the epidemiologists can help us. There is a strong move on their part to work with health economists to consider the cost effectiveness of preventive approaches within the new public health. If we can justify this approach on economic grounds as well as on health grounds, policy makers in the health care sector may well encourage us to continue to do this.

Disciplinary Overlap

Yet another implication arising from these issues is that of the marked overlap between disciplines that occurs when a patient or client is regarded as a whole person. Rather than treating symptoms that conveniently fit into one specialty, or requiring approaches that come from one discipline, the focus we are dwelling on today is on the person as an integrated whole, and it is therefore disadvantageous to the individual to impose artifical separation when supporting an improvement in quality of life.

In an excellent paper presented last year at the World Confederation of Physical Therapists, Carol Davis discussed her transdisciplinary model, and the importance of allowing professional boundaries to be transcended (Davis 1987). She pointed out that there is no need for us to be concerned about losing our professional identity once we have consolidated it, but we need to consider gaining the ability to bracket this identity; that is, to set it aside without destroying it, and to allow our role to blend in with those of others from different disciplines for the benefit of our clients.

To be able to do this we must feel secure in ourselves and our profession, so that we do not regard it as a risk to do this bracketing. The more mature we are, Davis says, the more easily we can allow territorial boundaries to be blurred. So we have a large task ahead in this regard — to question and confirm our faith in ourselves, and then to work at developing shared values with those from other professions with whom we will be working.

Victim Blaming

Yet again, an important implication arising from any plea to enable individuals to become self-reliant and self-responsible concerns the concept of victim blaming (Crawford 1977). Because the new public health addresses those aspects of individual lifestyle and behaviour that are inextricably bound up with our health status, it is natural that a lot of the accent on remedying the situation is concerned with individuals making changes themselves. We have already considered the importance of looking at coping skills from the individual's point of view, and we have addressed the relationship issue where it has been suggested that health care practitioners need to relate in a mutually satisfying way and allow patients and clients to

be responsible for making decisions when appropriate.

But bringing forward the idea that people are responsible for the attainment of their own good health can lead to this idea being taken to its extreme. These same people can then be blamed for things going wrong, and the illnesses or disabilities that may ensue. Proponents of the victim blaming theory see moves towards self-reliance as dangerous steps, threatening to overload the individual with responsibility without that person having the power to be in control. They suggest that structural and environmental change are the only reasonable ways for people to be helped to be healthy, and that within this framework health professionals like us have a role as advocates and mediators.

I see two answers to this criticism.

Firstly, protection, prevention and promotion need to be seen as the responsibility of governments as well as professionals and individuals. It goes without saying that any government action that can contribute to optimizing health and well-being for our society as a whole should be implemented without hesitation. We are all aware that safe drinking water, adequate housing and such legislation as seatbelt and drink-driving laws have saved more lives than could ever occur by relying on individual willpower. The two are not mutually exclusive; they are complementary. We have an important role in promoting self-responsibility while authorities have a crucial role in altering environments and structures, both with the same goal of improving health status.

Secondly, the issue here is one of balance. Too much dependence on health professionals is unsatisfactory, but unreasonable dependence of ndividuals on themselves is just as bad. What is needed is a balance. Our role in keeping Australians healthy is to maintain this balance and to enable individuals to choose between a greater variety of options. It would be ideal if this ancient Chinese saying reflected our approach:

> Go to the people . . .
> Start with what they know,
> build on what they have,
> but of the best leaders
> when their task is accomplished
> their work is done
> the people all remark
> we have done it ourselves.
> (Lao Tsu circa 500 BC).

Physiotherapists have a tremendous part to play in the field of the new public health. As a group, we are strongly committed and have high professional ideals. Now that we have determined what we can do, the time is ripe for us to get on and do it.

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